MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, March 18, 2004
10:06 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:
Dual eligibles: A profile - Anne Mutti

MS. MUTTI: This presentation follows up on our discussion about dual eligibles that we had in January. At the January meeting, as you might recall we talked about their eligibility requirements and the coverage and payment policy for duals. Today we're going to talk about their demographic characteristics as well as their spending patterns. In April we hope to come back to you then with a draft chapter that incorporates this information and also pulls together some more information on spending patterns as well as quality and access information.

Today perhaps the best way to frame this discussion is to pick up on a question that was asked at the last meeting, and that was, what are the characteristics of a typical dual beneficiary?

So first let me take a look at demographic characteristics, but I need to take just a moment to talk to you about how we define dual beneficiaries and how we counted them. We included all those who are fully dual eligible, including the medically needy. We also included those people who are qualified Medicare beneficiaries as well as specified low income Medicare beneficiaries. These people are not entitled to the full range of Medicaid beneficiaries. They have help with their premiums and in some cases also their cost-sharing.

We further refined our definition duals by counting someone in these categories as duals only if Medicaid was their predominant source of coverage throughout the year. These definitions are slightly different than the ones that were used for the disease management work so you'll notice some discrepancies but nothing that really changes the fundamental picture here. I should also add that our analysis is based on 2001 MCBS cost and use data, and also that it was largely or completely performed by Sarah Lowery on our staff with the help of Dan Zabinski. Unfortunately, neither of them could be here today.

Now let me turn to the demographic data. Relative to non-duals, duals are far more likely to be enrolled as disabled, and therefore be under 65. In fact they are 2.5 times as likely. They are also more likely to be over 85. So of duals, more than one-third are under 65 and about 14 percent or over 85. These two subpopulations, therefore, account for 50 percent of all duals. The remaining 50 percent is fairly evenly divided between these two age categories.

Relative to non-duals, duals report worse health status. The majority report good or fair status, but just

over 20 percent report poor health status and 17 percent report excellent health status.

Relative to non-duals, duals are more likely to have greater limitations in activities of daily living, such as bathing or dressing. 33 percent have difficulty with three to six ADLs. But it is notable that 45 percent of duals do not have any limitations in these activities. Almost one-quarter of duals reside in an institution compared to 3 percent of non-duals. And while a small proportion live with their spouses, a larger percentage live with others, such as family members.

Over 60 percent of duals live below the poverty level and almost 95 percent live below 200 percent of the poverty level. Some of the details on these statistics are in your mailing materials on page two if you would like to refer to that. They are more likely to be female; 62 percent of duals are women, and of a minority population; 43 percent are minorities, and live in rural areas. It's about 27 percent of duals compared to about 23 percent of non-duals in rural areas. Few have other sources of supplemental insurance. Those that do tend to have it through programs like the VA or state-sponsored drug plans.

So the summary that I would like to pull out of these various statistics is that the areas that we see the greatest relative uniformity within the dual populations are with respect to being poor, poorly educated, minority, and having no other sources of supplemental coverage.

We do see substantial variation in other areas, especially in the area of age, the relative level of disability as defined by difficulty with the ADLs, their living arrangement, and even with their reported health status. We see considerable variation with 17 percent reporting excellent and 21 percent reporting poor.

This variation makes it difficult to identify the demographic and health status characteristics of the typical dual beneficiary and leaves us to look at subgroups of beneficiaries as a more useful tool for examining what's going on with duals. We're going to come back to that at the end here.

Next we looked at spending patterns for the dual population. Let's start out with our broadest statistic. While dual beneficiaries account for 15 percent of all beneficiaries, they account for 22 percent of Medicare spending. In this analysis we find that the average per capita Medicare spending on a dual beneficiary is about $8,560, which is about 68 percent higher than non-duals.

Next we looked at the factors behind this higher spending on duals and examined spending for duals and non-duals by service area. We found that average per capita spending for duals is higher for each service area, and in

particular spending for inpatient, outpatient, SNF and hospice services are more than twice as high as that for non-duals.

We found that this higher spending average is a function of both a greater proportion of users and higher spending among users in the dual population. Overall, duals are more likely to use Medicare-covered services; 92 percent used any service compared to 89 percent of non-duals. But the difference can be much more significant by service area. For example, duals are almost twice as likely to use SNF services than non-duals. We also found higher spending among those who use services. This indicates that those duals who use services received a greater volume and/or intensity of services compared to non-duals. The greatest differences were found in outpatient, hospice, and physician services. For example, spending on outpatient service for duals who used the service was about 70 percent than that for non-dual users.

We then examined the distribution on Medicare spending on dual eligibles and found that spending is considerably concentrated on a minority of dual beneficiaries. Looking at the left-hand and the middle columns in this chart you can see that the costliest 4 percent of dual beneficiaries account for over 40 percent of Medicare spending on duals. The costliest 20 percent accounted for about 80 percent of spending, and the least costly 50 percent accounted for about 3 percent of spending. For these people Medicare spend about $1,700 or less in 2001.

We also looked at total spending on duals, and that refers to the combination of Medicare, Medicaid, and out-of-pocket spending. Average total spending for duals we found was about twice as high as that of non-duals, about $20,000 compared to $10,000. If you look at the right-hand and center columns you can see the spending distribution of total spending. The distribution is similar to that of Medicare spending for duals but is less concentrated. The costliest 5 percent account for 27 percent of spending as opposed to 41 percent for Medicare. Similarly, total spending on the least costly 50 percent is 9 percent compared to 3 percent for Medicare spending.

So to summarize the findings that were just mentioned on that chart, we find that, as with non-duals, there is tremendous variation within the dual population on Medicare service use. Some duals are incredibly costly while many are not, which again undermines our summary generalizations about the typical dual beneficiary's health care use.

Despite this diversity within the dual eligible population, duals are still, on average, much more costly

than non-duals. Accordingly, duals represent the disproportionate share of the overall most costly beneficiaries. Of the 5 percent most costly beneficiaries overall, one-quarter of them are dual. Of the 1 percent most costly beneficiaries overall, one-third of them are dual. Then as we just noted in the last slide, total spending on health care for duals is double that for non-duals and is somewhat less concentrated than Medicare spending on duals.

Now that we have demonstrated the significant diversity in the dual population we hope to shed some more light on the subpopulations that are evidence based on age and type of disability that beneficiaries may have. So we've decided to look at various subgroups and we've identified those, both in the categories of disabled beneficiaries and aged beneficiaries, the following three categories: those that have mental or cognitive disabilities, those that have limitations in two or more ADLs, and those that have limitations in less than two ADLs. So that would be six categories altogether.

For each of these subgroups we plan to look at the proportion of the dual population they represent, their service use and spending patterns, and compare this to non-dual with the same characteristics. And we'll take a look at the proportion institutionalized.

As I mentioned at the beginning, we also plan to look at data on access and quality of care. I think there's a few other threads that we wanted to pick up based on some of the questions that we got last time in terms are what are the patterns, length of eligibility as a dual and see if we can't find out a little bit more about that. Then we also would like to do a little bit more work trying to parse out, of the total number of duals what percent are medically needy, what percent are QMB only, and what percent are SLIMB only. We just need a little bit more time to look at that.

So at this point I think I'd like to stop and get your thoughts on this analysis and any other questions.

DR. REISCHAUER: Anne, I thought this was very interesting work that you're doing, and your last comment fed right into the one reservation I had about this. That is, it's one group of apples and one group of oranges. Pure duals, QMBs and SLIMBs are all there because of their incomes. The medically needy are there because of their high expenditures. So in a sense you say, these people cost a lot when you've chosen a chunk of them because they cost a lot and it's hardly a eureka moment.

I think maybe, when you can, separating the two, at least one for some of the purposes would be of interest, because the medically needy come from a much larger population, some of whom then get sick and spend down and

there they are. And by definition they're going to have all these characteristics that we're saying, isn't that big?

MS. MUTTI: Right. And it would also be nice to look at their Medicare spending versus their total spending, how much higher too.

MS. RAPHAEL: The other thing I was interest in is when you look at Medicaid for the dually eligibles you find the same pattern, that a small percentage of Medicaid patients account for a large proportion of expenditures and it very much correlates with dual eligibility. I'm wondering if there's anything we can say about that.

MS. MUTTI: I guess I would like to take another look at the data we have to see what patterns we're seeing. Then it might be interesting as we look at these subcategories to see if we see different ratios along those lines.

DR. REISCHAUER: Run that by me again, Carol. The concentration of Medicaid spending?

MS. RAPHAEL: Yes, if you look at -- this is what I remember and I'm not sure I remember it accurately.

DR. REISCHAUER: But Medicare is a primary payer so people who are dual will have a big chunk of their expenditures paid by Medicare and appear to be, in a sense, relatively cheap Medicaid folks relative to the rest of Medicaid.

MS. RAPHAEL: That's what you would think.

DR. REISCHAUER: Except the ones that are in nursing homes, long-term care.

MS. RAPHAEL: Right. I'd be interested in that.

MS. MUTTI: That's why I think some of the subgroup analysis where we show the elderly versus the disabled or something, those people who are more likely to be institutionalized, what the Medicare compared to Medicaid spending looks like might be interesting.

MR. DURENBERGER: As I have followed the work that everybody is doing, it's a very comfortable progression to lay a foundation under what hopefully will become at this level a discussion about how to advise the Congress on the future of Medicare payment policy. This is just a report, and Sheila Burke isn't here today, but last week at the Kaiser Commission on Medicaid and the uninsured we spent a lot of time looking at the future of Medicaid and all that sort of thing. One of them specifically was the area of dual eligibles. The similar kinds of issues that get raised by the data here were raised, obviously, and discussed there at some great length, in terms of the fact that the Medicaid program filled in a lot of the gaps in the benefit structure or the cost-sharing structure or whatever. Bob has already alluded to some of the reasons. But some of it is structural.

Secondly, that the failure, if you will, as we looked at it from back in 1988, to build some long-term care coverage in through Medicare causes a substantial amount of the Medicaid dollar to go into it. The challenge there is that so much of that money is directed toward institutional care as opposed to community home-based and so forth one, which one would hope might come if it were more of a social insurance program than a welfare-like program.

Then thirdly we looked at, what's the implication of MMA, and the fact that in their wisdom the Congress has decided to move the prescription drug part of the coverage for dual eligibles into the Medicare program, but then asked the states to pay for it; the so-called notion of the reverse block grant. It left us as a group in some kind of doubt about where this administration, this Congress may be headed in terms of most appropriate public financing for access for the 51 million now served by Medicaid.

But in particular, where there is this major and expensive overlap for the 7.5 million people who are dual eligibles, what's going on in their heads? Is there anything on purpose about the federalization of the obligation to provide prescription drugs for the dual eligibles? Is there any more to be read into that in terms of using the Medicare program further to serve the health-related needs of people who are dual eligible?

The bottom line when we were asked as a group to look through what was our consensus as to what the staff ought to look at more we said, we ought to look more at the role that Medicare, or an expanded Medicare ought to be playing with regard to your dual eligibles and everything else, period. Nothing more than that.

So I'm just, as a matter of reporting that the commission and those of us who are advisory to the commission are going down a parallel track, and just as one who overlaps the two commissions I'm hoping that at some period of time after we put more of a base under this we can begin to start answering questions at least that we had last week, which is, should not the Medicare program be designed in a different way to cover more of the health-related needs of the dual eligibles? And if so, might that result in more or less economies, efficiencies or whatever if that were to happened?

Nobody at this stage knows the answers to those questions, but because we don't feel that those answers are coming from the Congress, from the administration. Everybody looks at the deficits and says, where's the money going to come from? You look at the states, there's no resources there. Yet there are 7.5 million very vulnerable Americans in this population, as we pointed out, to whom both of these organizations see themselves -- both MedPAC, I

would hope, and Kaiser see themselves as having some kind of responsibility to give some advice to the Congress about this large volume of public financing and how it might be more appropriately used.

MR. HACKBARTH: In MMA, did the administration initially support bringing the drugs into Medicare? I thought they wanted to leave it with the states.

DR. REISCHAUER: The dual eligibles --

MR. HACKBARTH: So it was from the Congress that that idea came and then the administration said okay, with a clawback basically.

Any other comments on dual eligibles?

Okay, thanks, Anne.